

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2010
NAME OF PROVIDER OR SUPPLIER BRIDGE AT MONTEAGLE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 26 SECOND STREET MONTEAGLE, TN 37356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During the annual survey from March 16, 2010 to March 18, 2010 and investigation of complaints #22281, #23879, #25311, #23655, and #24912, no deficiencies under 1200-8-6 Standards for Nursing Homes were cited.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

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If continuation sheet 1 of 1